

**PATIENT / INSURED TO COMPLETE TOP PORTION (1-13)**VGCLM - 998

PATIENT AND INSURED (EMPLOYEE) INSTRUCTIONS

1a. INSURED'S I.D. NUMBER

Enter the insured's identification number, including a prefix or suffix, exactly as it appears on the insured's identification card.

2. PATIENT'S NAME

Enter the last name, first name and middle initial of the patient. If the patient is the insured, spell the name exactly as it appears on his or her identification card.

3. PATIENT'S BIRTHDATE, SEX

Enter the month, day and year of the patient's birth. Place an "X" in the box which indicates the patient's sex.

4. INSURED'S NAME

Enter the last name, first name and middle initial of the insured. Spell the insured's name exactly as it appears on his or her identification card.

5. PATIENT'S ADDRESS, TELEPHONE NUMBER

Enter the patient's home or mailing address. This should include an apartment number, rural route, street number, street, post office box number, city, state and zip code. Enter the telephone number including area code.

6. PATIENT'S RELATIONSHIP TO THE INSURED

Place an "X" in the box which indicates the patient's relationship to the insured.

7. INSURED'S ADDRESS, TELEPHONE NUMBER

Enter the insured's home or mailing address. This should include an apartment number, rural route, street number, street, post office box number, city, state and zip code. Enter the telephone number including area code.

8. PATIENT'S STATUS

Place an "X" in the box which indicates the patient's status.

9. OTHER INSURED'S NAME, POLICY, EMPLOYER, PLAN

Enter other insured party's name (last, first, M.I.); (a) other insured party's insurance policy or group number; (b) other insured party's date of birth and sex; (c) other insured party's employer or school name. The employer is an institution, organization or individual providing the principal source of medical coverage or financial support. Enter the name the other insured's school if the other insured party is a full-time student; (d) other insured party's plan or program name.

10. PATIENT'S CONDITION RELATED TO:

Place an "X" in the appropriate box, if the medical condition being treated is related to one of the listed situations.

11. INSURED'S POLICY, EMPLOYER, PLAN

Enter insured's insurance policy group number; (a) insured date of birth and sex; (b) insured's employer or school name. The employer is an institution, organization or individual providing the principal source of medical coverage or financial support. Enter the name the insured's school if the insured party is a full-time student; (c) insured's plan or program name; (d) enter other insurance health benefit plan if any.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

The patient is to sign the claim form, authorizing the release of information, as provided below. If the patient is a minor, the signature must be that of the patient's parent or legal guardian.

"I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish any and all records pertaining to medical history, services rendered, or treatment given to me or my dependents for purposes of review, investigation or evaluation of this claim.

I also authorize Vytra Health Plans, or its agents, to disclose to a hospital or health care service plan, self insurer or an insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a Group Contract held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of this claim or term of coverage of my insurance policy, including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon the claimant, his heirs, executors or administration."

INSTRUCTIONS: Attach original bills to this completed form and mail to Vytra Health Plans.

PHYSICIAN OR SUPPLIER INSTRUCTIONS *(Refer to billing instruction guide)*

Complete the physician or supplier section of the claim form and mail to:

Vytra Health Plans

PO Box 9091

Melville, NY 11747-9091